

reviews

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Menopause and Hormone Replacement Therapy: Effective Patient Care

Nancy Avis, Isaac Schiff

Silver Platter Education, \$149, CD Rom
ISBN 1 57276 0400

Rating: ★★

The current debate about hormone replacement therapy and the menopause among healthcare professionals and the public makes any material on the subject both highly topical and of interest to a wide audience. Because of its wide coverage of the different issues, this CD Rom will appeal to medical practitioners from many disciplines and to healthcare profes-

sionals such as nurse practitioners. Despite its American bias, the versatility of the package should make it relevant to both primary and secondary care.

It has a patient centred focus, in which the attitudes of women to the menopause and hormone replacement therapy are considered and respected as part of the delivery of effective care. Several interesting features combine to make this package extremely easy to use and highly flexible. Users can access the same problem from different aspects, such as reviews of major studies or women's attitudes, or search through the contents for key words. The transcript view also allows users to quickly review the contents.

Through the case studies presented—all of middle class US women—users can interact with the patient and the “expert” physician by means of series of well sequenced questions and video clips. This can engage both the novice and the expert by providing support in reasoning processes

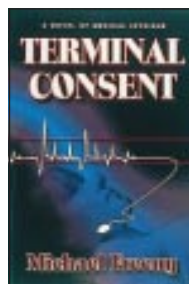
and diagnostic skills. One of the most innovative aspects of the CD is that users are encouraged to develop their own presentation for colleagues or patient groups using the slide material available. There is also material, which can be adapted and added to, to download and use as handouts for patients or for student tutorials.

The only major drawback of this CD is that the management decisions are based on US practice, although the chapter reviews do attempt to cover UK practice, and current evidence is discussed in relation to the care of the patients presented. Also the only “light” aspect to this package is the use of diagrams to relate pathophysiology to clinical presentations. However, as a general practitioner with an interest in women's problems, I was sufficiently enthused to download materials for my practice—a virtual first.

Jean Ker general practitioner lecturer in medical education, Curriculum Development Office, University of Dundee

Terminal Consent

Michael Freeny



William Austin Press, £9.14,
pp 371
ISBN 0 9663686 6 5

Rating: ★★★

When George Orwell wrote *1984* in 1949 the free world had just destroyed two totalitarian regimes and still faced another. The idea of Big Brother was all too real, even though the technology that Orwell described was not. Michael Freeny, an American psychologist, has written a novel somewhat like *1984*, but this time the technology is all too real, and the threat comes not from a political regime but from the marketplace. The reality of modern information technology makes this book terrifying.

When we pay our bills or use our credit cards, banking machines, and physicians'

services, data are gathered. They are used for dozens of purposes, including personal marketing, credit checks, and quality measurement. If all these disparate databases through which our habits are tracked were put into one information system, one would have “MOM,” the novel's MultiAxil Outcome Management system.

In this book a journalist and a psychologist slowly realise that a computer that began as a medical decision aid has grown into a comprehensive manager of millions of individuals' lives. MOM is able to track medical decision making, of course. But the giant insurer that owns the system uses it to track costs of care against the cost of potential lawsuits, to unload doctors who “cost too much,” and to skim the cream by avoiding insuring patients with chronic diseases. In addition, Great Health Benefit executives use medical information against politicians seeking to reform the US healthcare system and sell patients' data to almost anyone. An antiabortion group buys such a list and uses markers for pregnancy and gynaecological surgery to find women who have had abortions and then uses that information to extort money from hundreds of thousands of women.

If this scenario seems farfetched, one might look at recent insurance mergers in the United States. Aetna gobbled up US Health Care and, just recently, Prudential's health plans. Aetna now insures 22 million people,

about 10% of all Americans and 20% of all those covered by private insurance. In its quest to cut costs and ensure profitability for its investors, Aetna will have to use as much information as it can gather legally, and Freeny points out that such data are virtually limitless in our digital age.

Freeny's scenario is terrifying because it is so possible. Unfortunately, his prose and plot do not match Orwell's, or even live up to this book's own theme. Ruthless executives are not only stereotyped but also yell exclamations such as “Damn” and “Heck.” The protagonists are likewise stereotyped as purely moral. The plot and its outcome are predictable by the end of the second chapter.

None the less, *Terminal Consent* is an easy but chilling read for a general audience. It is medically sophisticated enough to please physicians. (The author offers continuing medical education credits for health professionals.) As information systems are synthesised, it would be wise for political leaders to read this book, as well. Who, if anyone, do we trust to use information most judiciously for good? The use of it already has gone beyond individuals, such as doctors, and the debate now is whether it will be managed by government or the marketplace. We should choose soon.

John C Roberts general internist, Bellingham, Washington, USA

Reviews are rated on a 4 star scale
(4=excellent)



Doctors from Hell

The Cook Report, ITV, 9 00 pm Tuesday 24 August

“**W**ould you let any of them treat you?” challenges Roger Cook, after reeling off a list of “doctors from hell,” and quickly provides the answer: “Tonight we go undercover to examine the scandal of the doctors you’d never want to treat you or your family.”

Cook is an avenging angel of gargantuan proportions, and crooks and swindlers of every hue are his target. Why, then, should miscreant doctors be spared? Lulled into a soft admission or compromising position, Cook’s quarry seldom know what to do when confronted by his robust inquisition and a microphone thrust in their direction. Fight or flight? Silence is the usual answer, but the verbal battering from Cook leaves little doubt as to the culpability of the accused.

His huge frame undoubtedly helps—usually deterring a direct assault, although Cook has taken blows in the past. Little matter, it all makes for great television, and Cook knows he can push his trial by camera to the limit. The other advantage of his size is that, once he has you cornered, escape is purely by his leave. Blocking doorways, holding open car doors, or filling passages, Cook is a formidable adversary.

His style is to present a potted history of his target’s failings—be it sexual assault, stalking, selling off donated blood, or falsifying sick notes—supported by covert filming or sorrowful recollections from those who have suffered. Once the viewer is outraged, Cook pounces, albeit slowly.

However, his main weapon is surprise, and many of Cook’s medical prey were too startled to move, let alone speak. “You gave them hell, didn’t you, Dr Heaven,” intoned Cook, as he squashed the startled doctor between the door of a hospital residence and a wall. Dr Heaven had been convicted and fined for making menacing telephone calls but now, which is what was perturbing Cook, he was back at work and getting on with his life while his victim was still traumatised by her experience.

Dr Unni, a psychiatrist barred from practice in New Zealand and more recently struck off in England, merited an analysis by a clinical forensic psychologist as well as an undercover consultation by a bogus female patient to demonstrate Dr Unni’s over-friendliness. When Cook caught up with him in a hospital car park, Dr Unni froze, mumbled a few words, and then ran for the door. Alas, Cook had to leave it at that.

The ultimate indignity, however, was saved for Dr George Udenkwo. Cook and his team set up an elaborate sting whereby an undercover reporter acquired a sick note from Dr Udenkwo to support a medical insurance claim after a supposed car crash. The deal was that Dr Udenkwo would get 20% of his £5000 claim, but, as Dr Udenkwo was receiving his first payment, Cook was tapping on his shoulder. “There’s no answer is there, Dr Udenkwo,” taunted Cook, pointing at the wad of money in Dr



Dr Unni is confronted by Cook

Udenkwo’s hand, “There’s the evidence. You did it.”

A fair cop? Perhaps. But, as Steve Boulton, former editor of the current affairs programme *World in Action*, pointed out in the *Guardian* on the morning of the transmission, Cook’s rise was aided by antics that would shame his current employers. “Many in TV expected him to come to grief long ago. Miraculously, the heavyweight inquisitor has always skipped lightly away from the wreckage,” explained Boulton.

Whatever his methods, Cook gets results. And his assertion that the GMC’s current rules should be changed so that doctors can be struck off for life was supported by a MORI poll reported on the programme. Seventy five percent of those surveyed wanted life bans for doctors, and 84% said that they didn’t want to see a doctor who had been struck off and then reinstated, though only 8% were prepared to find out about their doctor’s past misdemeanours.

Confronted with this evidence Frank Dobson, the secretary of state for health, told Cook: “If they [the GMC] come to me asking me for a change in the law, they’ll get it.” It was then revealed that, within an hour of Dobson’s talk with Cook, the GMC issued a press statement promising that the issue would be debated at its next meeting, in November. Sir Donald Irvine, president of the GMC, pointed out: “A community of 100 000 people [doctors] contains all the dimensions of human behaviour that you find in the population.”

Is a more punitive attitude a bad thing, when trust plays such a fundamental role in the doctor-patient relationship? No, but the thrust of Cook’s programme suggests that doctors who are struck off should never practise again. The reality, however, is that the full spectrum of crime deserves a broad range of punishment. A proportion of doctors who are disciplined will serve their time and should be allowed to practise again. However, the option of permanently striking off doctors for some offences should be available too.

Love him or loathe him, Cook’s crusade strikes a populist chord. The programme is tabloid television at its most powerful and is captivating viewing—but not much fun for his victims, or, indeed, for their patients who happened to have tuned in.

Kamran Abbasi *BMJ*



WEBSITE OF THE WEEK

Earthquake disaster in Turkey From the first unconfirmed reports of 250 people believed dead in Turkey on 17 August to official figures of 14 000-18 000 dead just a week later, the Turkish earthquake disaster has hit media and humanitarian aid websites alike. Both the International Red Cross (www.ifrc.org/news/specials/turkey) and Médecins Sans Frontières (www.msf.org/projects/turkey) offer wide coverage with daily news updates. The International Red Cross has published several particularly harrowing pictures on its site, accompanied by some graphic, on the scene reporting. It also explicitly asks for financial donations to support its aid work in the area.

Médecins Sans Frontières (MSF) has collated news reports from the BBC and CNN and says that “because of the massive intervention of non-governmental organisations and governments, MSF involvement does not need to be widespread in Turkey.” The website does, however, describe the MSF plan of action in Turkey, which is to install “MSF Health Houses” (tents set up with medical staff to cover basic medical needs, including mental health needs), to install water and sanitation facilities, and to “continually measure the epidemiological situation.”

Away from the scene itself, at www.disasterrelief.org/Disasters/990825Turkey9, a reporter had turned to arguably one of the more delicate aspects of the situation. An interview with Prime Minister Bulent Ecevit reveals his admission that downed bridges, blocked roadways, and telecommunications failures had slowed response to the disaster. But even more revealing is the website of the Office of the Prime Minister itself (www.byegm.gov.tr/), which, at the time of writing, made no mention of the earthquake at all but waxed lyrical about the 27th International Istanbul Music Festival. Perhaps they have all been too busy to update their news pages.

Abi Berger
BMJ
aberger@
bmj.com

PERSONAL VIEW

My years with Lyme disease

I first became unwell in the wake of some students sadly succumbing to the meningococcus. I had non-specific symptoms—malaise, fatigue—but with the photophobia, headache, and difficulty on my feet they were serious enough to warrant admission to the neurology ward for investigation. The investigations were thorough, but no cause was found.

I was discharged back into the hands of a less than sympathetic university health service, and it was here that the mysterious spectrum of symptoms that graced my life earned me the title “malingerer,” chiselled deeply into my notes and even deeper into the clinical opinions of all those who saw me thereafter.

My aching joints were scrutinised by the rheumatologists. The neurologists put me under the inquisition again, trying to find some explanation for the interminable headache. Ultimately, as is often the case, I was directed to the psychiatrists. A label of “depression” was hung around my neck, and I spent several months at a loose end, my studies on ice, convinced that I was not psychiatrically unwell, yet being swayed increasingly to the point of view that I was somatising.

A rather unhelpful faculty of medicine hindered my progress, and for a few years I let my body smoulder away gently, reluctant to grace a doctor's surgery. A constant headache was my shadow, my joints protested, and I had strange things happening to my skin—things I ascribed to a bad mattress, poor posture, worn out running shoes, and a hot bedroom rather than anything else.

In the end it was easier to live with the symptoms rather than be ridiculed by those from whom I might seek advice. I learnt to accept the devastating effect that this malady was having on myself but most importantly on others. Constant pain, feeling permanently hung over, being unable to stand properly, and soaking erstwhile sleep partners, courtesy of night sweats, did not augur well for relationships.

It seemed odd to me that the first time that a proper history was taken was when we knew the diagnosis. I had seen numerous specialists, but nobody had actually taken a full history; a point I had difficulty reconciling and even greater difficulty putting across. I stumbled over the diagnosis myself just before sitting my finals.

Walking one day at Haworth, in a moment of serendipity, it all became rather

clear. The topic of conversation was tick borne diseases and a profound dénouement took place. Yes, before becoming unwell I did recall the rather pathognomic skin rash of *Erythema chronicum migrans* after climbing in Canada and Switzerland. Indeed I recollect the initial lesion very well. Out of curiosity I had mapped out its perimeter as it spread up my leg.

All that followed was easy to ascribe in retrospect to the spirochaetes and their passage through my body. When the serology came back I was delighted to find myself with Lyme disease. It was the greatest positive affirmation that I could have wished for. Soon after finals I underwent a rather unpleasant course of chemotherapy and then started in clinical practice.

The legacy of a decade of grumbling Lyme disease no doubt debilitated me physically. And the stigmatisation of a label and frank derision by doctors led to a gnawing psychological dimension.

Towards those who did not take me seriously I do not feel bitter. I pity them and hope that nobody else falls foul of them. To those at Bradford Royal Infirmary who took me seriously and gave me a chance to flourish I can never extend enough thanks. I extend similar thanks to the communicable disease directorate in Sheffield and to supportive friends.

Regarding the effect my illness has had on my own clinical practice, I hope that I can reach the zenith of equanimity and open-minded consultations that I might have benefited from. It was fortuitous to have discovered Lyme disease. I was not on any form of crusade.

It was luck that the discussion about Lyme took place and that I happened to be in the right profession. Above all, I am fortunate that its course has been relatively benign. My awareness of Lyme disease predated my discovery by four years or so, and I did ask myself why I did not think of it earlier. It was probably because I was not on a crusade. In any case I doubt if I would have been taken seriously.

Rare as Lyme disease is in the United Kingdom, I suppose there must be a small but significant population of those suffering from undiagnosed chronic Lyme disease, and I hope that they have sympathetic general practitioners looking after them. A headache of sorts is my inseparable companion and from time to time reality, just like those ticks in 1987, bites.

Chris J F Wilson, surgeon lieutenant, Royal Navy

SOUNDINGS

Assets for the meritocracy

In Monty Python's transplant sketch, a man is sitting nonchalantly minding his own business when there is a loud knock at the door. Enter an officious, clipboard-carrying administrator, closely followed by several white coated technicians who are vigorously sharpening their scalpels.

“Mr B?”

“Yes, that's me.”

“We're from the Transplant Agency. You signed a donor card, I believe.”

“I did.”

“Well, we've come for your liver.”

“But I'm not dead yet.”

“It doesn't say anything here about needing to be dead. Now if you wouldn't mind lying down immediately on that table, sir. You see, the patient is very ill and you're a perfect tissue match.”

And so it continues. I was reminded of this peculiarly British genre of black humour the other day, when a friend recounted a telephone call he had had from his old medical school.

“Congratulations on your recent retirement, sir. Now, may I ask you if you have made a will?”

“No I haven't. I've only just turned 60.”

“Well, sir, you can never be too careful. You might like to leave a legacy to support the college's hardship fund. May I remind you, sir, that you yourself were fortunate enough not to have to pay fees for your education? I can send you the forms today, and someone can visit you to help you fill them out.”

My friend, like most of us, owes a great deal to his old medical school. He was an inarticulate boy from a poor family whose life would have been very different without a scholarship to grammar school and a genuinely free university place. But there is surely something questionable about a fundraising strategy that targets retired doctors and asks them to choose between underwriting the education of their own grandchildren and sponsoring an unknown youngster from the rough end of town.

As we prepare to welcome a new intake of medical students, we know that those without rich parents will struggle to make ends meet with a late night bar job, a colossal bank loan, and a pathological level of mental stress. Perhaps a more reasonable contribution for a school to ask of its alumni would be to keep reminding the public and the politicians of this unacceptable and worsening reality.

Trisha Greenhalgh general practitioner, London

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